STATEMENT OF

DR. JOHN D. DAIGH JR., M.D.

ASSISTANT INSPECTOR GENERAL FOR HEALTHCARE INSPECTIONS

OFFICE OF THE INSPECTOR GENERAL, DEPARTMENT OF VETERANS AFFAIRS

BEFORE

THE UNITED STATES HOUSE OF REPRESENTATIVES

COMMITTEE ON VETERANS AFFAIRS

HEARING ON DEPARTMENT OF VETERANS AFFAIRS

COMMUNITY NURSING HOME PROGRAM AND

HOMEMAKER AND HOME HEALTH AIDE PROGRAM

JANUARY 28, 2004

INTRODUCTION

Mr. Chairman and Members of the Committee, I am pleased to be here today to discuss programs that directly impact the quality of life of millions of veterans who need long-term care services. Today I will present you with the results of our evaluation of the Department of Veterans Affairs (VA) Veterans Health Administration (VHA) Community Nursing Home (CNH) Program and the Homemaker and Home Health Aide Program (H/HHA).

To provide you some background, VHA informed us that they have projected the number of veterans age 85 and older will increase from 645,000 in 2003 and will peak at 1.3 million in 2013. One of the methods that VHA uses to meet the growing challenge of providing health care to this population of veterans is providing nursing home care using contracts with privately owned nursing homes, state operated nursing homes, and VA-owned nursing home care units located in VA medical facilities nationwide. In addition to providing direct support for nursing home beds, VHA has established the H/HHA program under VHA Directive 98-022. This program provides

homemaker and home health aide visits to eligible veterans in their homes and communities using CNH funds. VA medical facility managers are required to coordinate and review the appropriateness of home care referrals, assess the most appropriate in-home services for patients, and monitor the appropriateness of costs. This program is consistent with the Veterans Millennium Health Care and Benefits Act, Public Law 106-117, which promotes the provision of non-institutionalized health care in community settings.

COMMUNITY NURSING HOME CARE

My office identified the need for VHA to strengthen CNH oversight and control practices as far back as January 1994. We found at that time that VHA needed to perform annual reviews, routinely use quality-of care information from state agencies in evaluating the quality and safety of CNHs, and conduct inspections and patient visitations to ensure veterans receive appropriate care. We also recommended that VHA develop standardized inspection procedures and criteria for approving homes for participation in the program to include quality oversight controls for monitoring the adequacy of care.

In October 2001, we reported to VHA that issues discussed in our 1994 report continued to exist at 17 facilities visited during Combined Assessment Program (CAP) reviews conducted from January 1999 through March 2001. In April 2002, we conveyed in our semi-annual report to Congress our concerns that VHA had still not responded to our recommendations to strengthen oversight of its CNH Program.

The General Accounting Office (GAO) also issued several reports on VHA's CNH Program dating as far back as 1987, and outlined similar control and monitoring vulnerabilities. A GAO report was issued in July 2001, and it discussed issues similar to those discussed in our 1994 report.

My inspectors reviewed past OIG and GAO reports on CNH activities and the status of recommendations that resulted from these reports. We visited 8 geographically diverse

VA medical facilities nationwide that contracted with 302 CNHs in their areas of jurisdiction. VHA CNH review teams monitored the care provided to 737 veterans in these nursing homes. We visited 25 of these CNHs, assessed the adequacy of VHA CNH oversight and control activities, and contract administration. We also reviewed a sample of 111 veterans' medical records at the VA medical facilities and CNHs. At each VA medical facility, we interviewed VHA CNH review team members and reviewed local policies. We interviewed the nursing home administrators and their directors of nursing, toured the physical plants, and interviewed veterans. We also reviewed data from the Department of Health and Human Services (HHS) Center for Medicaid and Medicare Services (CMS) On-Line Survey Certification and Reporting (OSCAR), contract files, and we interviewed State Ombudsman officials.

The veterans and families we visited informed us that they believed their respective CNHs provided generally good care, and they were mostly satisfied with CNH services and accommodations. However, the majority of VHA CNH review team members we interviewed were aware of reports that veterans were abused or neglected in CNHs under their jurisdiction. These teams acknowledged that they have generally reacted after the fact to these incidents. Actions have ranged from giving the affected families and veterans choices to transfer to other nursing homes, to removing veterans from nursing homes and canceling contracts. We found 9 reported cases of abuse, neglect, or financial exploitation during our review of the records of 111 veterans residing in 25 CNHs. This represents an average 8-percent incident rate in the sample population. We also found veterans who were not in our sample and non-veterans residing with our veterans in VHA-contracted CNHs who were subjected to serious adverse incidents. These conditions emphasized the need for VHA to strengthen oversight practices.

Rather than reacting to such adverse events, we believe VHA could reduce the risk of incidents occurring by strengthening their oversight of CNH activities. We found that similar program vulnerabilities as were discussed in prior OIG and GAO reports, continue to exist. Not all VHA CNH review teams analyzed CMS data before initiating contracts and prior to annual contract renewals. This was evidenced by the fact that the

8 VA medical facilities visited had placed 27 percent of the veterans in nursing homes that had been inspected and cited for serious violations. CMS provides detailed information about the performance of every Medicare and Medicaid-certified nursing home in the country. The data includes health care deficiencies found during the nursing homes' most recent state nursing home survey and from recent complaint investigations. The 8 VA medical facilities we visited had active contracts with 41 (14 percent) nursing homes listed on the CMS "Nursing Home Compare" website as having level 3 or 4 "level of harm" ratings – referred to as the "Watch List". Of these 41 CNHs, 7 (17 percent) were managed at VHA headquarters under regional contracts. The 41 CNHs were cited 273 times for administrative and quality of care violations.

My inspectors found that CNH contract procedures and inspection practices continued to vary widely among VA medical facilities. The standardization of contracting requirements and expectations placed on CNHs would reduce vulnerabilities and ensure veterans receive the same standard of care nationwide. Not all medical facility managers accepted the requirement that VHA employees visit and routinely monitor the adequacy of care provided to veterans. Therefore, while some VA medical centers conducted monthly CNH visits as required, others conducted visits only when patients experienced adverse events. In addition, VAMC clinicians needed to routinely obtain CNH performance monitors (e.g. resident falls, incident reports, and medication errors), to better monitor occurrences at these CNH facilities and to coordinate performance improvement initiatives.

My inspectors found that VHA CNH review teams do not meet annually with Veterans Benefits Administration (VBA) Fiduciary and Field Examination (F&FE) employees to discuss veterans of mutual concern as required by VBA policies. VHA does not have a corollary policy to discuss CNH patient issues with VBA representatives. We also found that VHA CNH review teams do not always contact VBA examiners when veterans' cognitive abilities change. The absence of effective communication between VBA and VHA reduces the VA's ability to adequately protect veterans from financial exploitation and protect VA-derived payments.

We made 10 recommendations to VHA[1], and the Under Secretary for Health (USH) agreed with all but one issue pertaining to monitoring patients who reside outside a 50-mile radius of VA facilities. We agreed that no immediate action was needed on this specific issue, but we encouraged VHA managers to closely oversee the adequacy of monitoring these veterans. We agreed only because VHA top managers assured us that they would consider visitation schedules on a case-by-case basis, and would tailor monitoring controls to the needs of each specific veteran residing in a CNH regardless of their distance to the VA medical facility. The USH provided acceptable implementation plans for the remaining recommendations. The Under Secretary for Benefits agreed with the recommendation to coordinate efforts with VHA in this area and establish proper procedures for exchanging information.

VHA published a new CNH policy on June 24, 2002, at the conclusion of our follow-up review in an effort to respond to earlier recommendations. We concluded this new CNH policy clarified and strengthened certain oversight controls and addressed many of the prior recommendations made in earlier reports, but the new VHA policy needed clarification. To date the CNH policy is still in draft stage and has not been released for concurrence.

HOMEMAKER AND HOME HEALTH AIDE PROGRAM

The H/HHA program began as a VA pilot program in 1993 to furnish personal care and health-related services in noninstitutional settings for certain eligible veterans. The program consisted of H/HHA services coordinated by VHA staff. The VHA's H/HHA Evaluation Project was completed in June 1995. The findings, published in the VA Guide to Long-Term Care Programs and Services, Volume 3, identified the following problems with the provision of services: dissatisfaction with the continuity of care (frequent changes in community health agency (CHA) care providers), quality control

[1] OIG Report No. 02-00972-44, *Healthcare Inspection Evaluation of the Veterans Health Administration's Contract Community Nursing Home Program*

and staff training varied between vendors, and inadequate staffing to administer the program.

My inspectors reviewed the H/HHA program between October 2001 and September 2002.[2] As part of the OIG's CAP reviews, we inspected H/HHA programs at 17 VA medical facilities. Our sample was composed of 142 patients, at 16 sites, who were receiving H/HHA services at the times of the CAP review visits, or who had received H/HHA services during the first quarter of FY 2002. All sampled patients had received services for at least 6 months at the times of our visits. We also consulted with OIG auditors who assisted us on the financial aspects of the review.

One of the 17 facilities we visited had no veterans who met the selection criteria of receiving H/HHA services for at least 6 months. This facility limited contracts to 3 months to serve as many veterans as possible. No data from the medical record reviews or the satisfaction survey of patients from this facility were included in this report; however, other program information was included.

We reviewed local policies and interviewed H/HHA Program coordinators and team members from contracting, billing, nursing, and social work to assess their compliance with VHA directives. We reviewed CHA's documentation regarding supervision and patient satisfaction, and performance improvement data to assess the quality of the H/HHA services provided to veteran patients. We reviewed the medical records of 142 patients receiving care at 16 medical facilities to evaluate initial interdisciplinary assessments, clinical eligibility, and re-certifications for continued services. We contacted 70 of the 142 patients in our sample, or their caregivers, to assess their satisfaction with H/HHA services. We recorded the perceptions of the patients or their caregivers regarding the timeliness of H/HHA services, the courtesy shown by homemakers or home health aides, and the levels of satisfaction with the program. We reviewed contractual agreements between the VA medical facilities and CHAs and

[2] OIG report 02-00124-48, *Evaluation of Veterans Health Administration Homemaker and Home Health Aide Program*

examined the invoices for patients receiving services during the first quarter FY 2002, to determine whether the CHAs complied with authorized rates and hours, and whether VA medical facility managers appropriately monitored the billings. We also compared the authorized rates to the local State Medicaid rates and the Department of Labor's Bureau of Labor Statistics Wage Rates to determine the reasonableness of the charges. We examined invoices for 142 patients. We utilized the Benefits Delivery Network (BDN) to determine whether veterans receiving H/HHA services were also receiving basic special monthly compensation or pension (SMC/P) benefits because of the need for basic aid and attendance.[3] We obtained copies of the rating decisions for 32 patients who were receiving SMC/P benefits to determine whether the SMC/P was provided for the same reasons for which the patients were receiving H/HHA services. We also determined whether H/HHA Program managers were aware of their veterans' SMC/P status. We verified the SMC/P status of 667 veterans.

We found that 20 (14 percent) of the 142 patients whose medical records we reviewed did not meet clinical eligibility requirements to receive H/HHA services. Five additional patients' medical records contained insufficient information to ascertain their clinical eligibility. According to VHA Directive 96-031, veterans eligible for H/HHA services are those who are in need of nursing home care. The phrase "…in need of nursing home care…" means that the patient's interdisciplinary team needs to make a clinical judgment as to whether such care is needed as defined by clinical indicators.

We found that 12 (8 percent) of 142 patients did not have any activities of daily living (ADL) dependencies documented in their initial assessments for H/HHA services yet were approved to receive services. In some cases, the interdisciplinary teams documented that the patients needed assistance with ADLs, but the patients were not dependent in any ADLs. In addition, we found that 7 (10 percent) of the 70 respondents interviewed said that they would not be in need of nursing home placement at this time

[3] In determining whether a veteran is in need of A&A, Veterans Benefits Administration adjudicators consider if the veteran's disabilities make it impossible to perform such basic functions of daily living as bathing, dressing, and eating without the assistance of another person.

even if they did not receive H/HHA services. The remaining 8 patients who did not meet clinical eligibility requirements had ADL dependencies, but did not have 2 or more of the other required conditions. We did not find any evidence of interdisciplinary assessments for referrals in 42 (30 percent) of 142 medical records reviewed.

H/HHA Program managers did not always appropriately manage their H/HHA resources in relation to wait-listed patients. We found that 10 (59 percent) of 17 VA medical facilities visited had waiting lists for placements in their programs. One facility had 23 patients on its waiting list, with 1 patient waiting 6 months for services. Another facility had eight patients on a waiting list to receive H/HHA services, and one patient had been on the list for 8 months. Three ineligible patients were receiving services through this latter facility, and a fourth (eligible) patient had repeatedly requested to terminate or reduce the hours of homemaker service he was receiving as he felt he did not have enough tasks to "...keep the homemaker busy." All eight wait-listed patients met eligibility criteria and may have been in greater need than some of the patients currently enrolled in this facility's H/HHA Program.

Contracts we reviewed showed hourly rates ranging from $9.86 to $30. We found that five sites negotiated rates below the prevailing State Medicaid rates, and saved about $6,800. Had the remaining 11 (69 percent) sites used the Medicaid rates, they could have avoided about $42,500 (16 percent) of the $265,849 in payments made for the patients in our sample, during the first quarter of FY 2002. In applying this percentage savings to projected FY 2003 payments for all H/HHA services, we estimated that the program could avoid, on average, about $10.7 million in costs annually. The H/HHA Program authorized services for 667 patients totaling at least $1.4 million at 16 sites we visited during the first quarter of FY 2002. Of these 667 patients, 163 patients (24 percent) also received basic SMC/P from the Veterans Benefits Administration due to their need for aid and attendance.

We recommended that the Under Secretary for Health (USH) issue a policy to replace expired VHA Directive 96-031 and provide additional guidance requiring that: patients

receive thorough initial interdisciplinary assessments prior to placement in the program, patients receiving H/HHA services meet clinical eligibility requirements, and that benchmark rates for these services are established. In addition, we recommended that VHA seek a General Counsel opinion as to whether a veteran's SMC/P status can be considered when prioritizing need for services and determining frequency of authorized H/HHA visits. If General Counsel determines that this consideration is appropriate, we recommend that policy reflect this decision. The USH agreed with the report's findings and concurred with the recommendations, but he expressed concerns about the monetary benefits that will be derived from implementing new policies and procedures. On September 10, 2003 VHA provided guidance that established benchmark rates for H/HHA services. Additional policy adjustments and the results of the General Council opinion, if available, have not been shared with the Office of Healthcare Inspections at this time.

CONCLUSION

In conclusion, we believe VHA needs to continue efforts to strengthen its long term care programs to ensure all veterans are receiving quality care and are safe from harm. My office continues to oversee this very important issue through the performance of program reviews and hotline investigations. We reviewed private homes providing health related services to veterans (Residential Care Homes) during CAPs performed in late FY 2003 and will be reporting on this issue in the near future. I want to thank you for the opportunity to participate at this hearing. I am available for questions.